JAMES VOGLINO, M.D.
Orthopaedic Surgeon
Sports Medicine & Rehabilitation
www.DrVShoulderHipKnee.com •305-596-3707
6705 Red Road Suite 606 Coral Gables, FL 33143

WELCOME TO OUR OFFICE!

Name: _____ Today's Date: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: ( ) _____ Cell: ( ) _____

Birthdate: _____Email Address: _____

Occupation: _____ SS#: _____

Employer: _____Work Phone#: ( ) _____

Employment Status: ___ Employed ___ Unemployed ___Retired

Ethnicity: _____ Race: _____Primary Language: _____

Sex: Male☐ Female☐ **Marital Status**: ☐Single ☐Married ☐Divorced ☐Widowed

Number of Children: ____

Primary Care Doctor: _____Phone: _____

Referring Physician: _____Phone: _____

Insurance_____Policy #: _____Group#:_____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____Relationship to Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone : ( ) _____ Cell phone : ( ) _____

Birthdate: _____ Email Address: _____

Insurance: _____Policy #:_____Group #:_____

In case of emergency, contact: _____Relationship: _____

Home Phone #: ( )_____ Cell Phone: ( ) _____

How did you learn about our practice? _____

I hereby consent to any medical care which is deemed advisable or necessary by my physician and grant authority to James Voglino,MD, to administer and perform all examinations, treatments and diagnostic procedures needed now or in the future. I guarantee payment for all services rendered. All medical benefits including major medical benefits, private insurance and any other health plan, are assigned to James Voglino, MD, PA. The signature below confirms all of the information provided herein is true and accurate. Photocopy of this consent is to be considered as valid as original.

Signature: _____ Date: _____

James Voglino, M.D.
Orthopaedic Surgery and Sports Medicine

Please Print
Today's Date: _____
Name: _____ Date of Birth: _____ Age: _____
Occupation: _____ Reason for visit: _____
Medical Information – Please List
Have you had any previous surgeries? Yes □ No □ If yes, please list surgeries and dates of surgery below:
Surgery_____ Date: _____
Surgery_____ Date: _____
Surgery_____ Date: _____
Surgery_____ Date: _____

Do you have any allergies? Yes □ No □
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

Are you currently taking any medication? Yes □ No □
If yes, please list all medications: _____
_____

Medical History – Please List
Do you have a **history** of any of the following? Please mark yes or no

Asthma	Yes □ No □	Lupus	Yes □ No □	Kidney Disease	Yes □ No □
Arrhythmia	Yes □ No □	Gout	Yes □ No □	Anxiety	Yes □ No □
Alzheimer's	Yes □ No □	Pancreatitis	Yes □ No □	Ulcers	Yes □ No □
Cancer	Yes □ No □	Tuberculosis	Yes □ No □	Cardiac Disease	Yes □ No □
Parkinson	Yes □ No □	Myocardial Infarction	Yes □ No □	Hepatitis	Yes □ No □
Liver	Yes □ No □	Renal Condition	Yes □ No □	Lung Disease	Yes □ No □
Diabetes	Yes □ No □	Gastrointestinal Conditions	Yes □ No □	Hypertension	Yes □ No □
COPD	Yes □ No □	Rheumatoid Arthritis	Yes □ No □		

Others: _____

Vaccines (including Covid): **Name/Administered Date**:
Vaccine _____ Date: _____
Vaccine _____ Date: _____

Do you drink alcoholic beverages? Yes □ No □ **Frequency of Consumption?** 1-2 a day □ More □ Socially □
Caffeine use? Yes □ No □ **Exercise**? Yes □ No □
Substance Abuse? Yes □ No □
Smoking History? No history □ Currently smokes □ Used to smoke □
Quit Smoking □ Second hand smoke □

Family History of Orthopaedic Injuries/Diseases? Yes □ No □
If yes, please list: _____
History of Osteoarthritis? Yes □ No □
History of Osteoporosis? Yes □ No □
History of Blood Clots? Yes □ No □
If yes to any, please list: _____
Social History – review of current and past social activities: _____

James Voglino, M.D.

Orthopaedic Surgery and Sports Medicine

Please Print

Name/Nombre: _____ Date/Fecha: _____

HEIGHT/ALTURA: _____ **WEIGHT/PESO:** _____

If the answer is yes to any of the following questions listed below, please circle its related description

Review of Systems	Description	Yes	No
Constitutional	Unexpected weight loss, weight gain, fever, chills, fatigue		
Eyes	Corrective lenses, blurred/double vision, eye pain, redness, watering eyes		
ENT	Headaches, difficulty swallowing, nose bleed, ears ringing, ear aches		
Cardiovascular	Chest pain, palpitations, fainting murmurs		
Respiratory	Shortness of breath, wheezing, cough, lightness, chest pain, snoring		
Gastrointestinal	Heartburn, nausea, vomiting, constipation, diarrhea, bloody/tarry stool		
Genitourinary	Frequent, urgent, difficult/painful urination, back pain, bleeding		
Skin	Skin changes, poor healing, rash, itching, redness		
Neurological	Numbness, tingling, unsteady gait, dizziness, tremors, seizures		
Psychiatric	Nervousness, anxiety, depression, hallucinations		
Hematological	Easy bleeding, bruising		
Endocrine	Excessive thirst, urination; heat/cold intolerable		
Allergic	Reaction to food or environment		

Chief Complaint / Dolencia Principal:

_____

_____

If occurred in an accident – please explain / Si ocurrio en un accidente - por favor escriba los detalles:

_____

Date of injury / Fecha del accidente:_____

Do you have a regular doctor? / ¿Tiene Usted un doctor Primario? Yes _____ No _____

If yes, who? / Nombre de su Doctor Primario _____

Phone Number / Numero de telefono: _____

Name of referring doctor? / Nombre el Doctor que le refirio a nuestra oficina?

_____

Additional comment / Alguna otra informacion?_____

Above reviewed by Dr. Voglino with the patient : _____ _____ Dr. Voglino: _____

James Voglino, M.D.
Orthopaedic Surgery and Sports Medicine

Patient Name: _____ Date: _____

Date of Accident: _____ Chief Complain: _____

1. **Location of Pain**: Shoulder□ Hip□ Knee□
Ankle□ Back□ Joint□
Other_____

2. **Describe pain**: burning□ cramping□ electric□
griping□ locking□ numbness□ sharp□
shooting□ stabbing□ cold□ can't describe□

3. **Intensity of pain**: Mild □ Moderate□ Severe□

4. **On VSA scale, patient states pain to be** :
1/10□ 2/10□ 3/10□ 4/10□ 5/10□ 6/10□
7/10□ 8/10□ 9/10□ 10/10□

5. **Pain radiating to :**
Left □ Right □ Bilateral□ Glutes□
Lower Extremities□ Other: _____

6. **Pain is aggravated by:**
Sudden movements□ Flexion □ Extension□ Rotation□
Walking□ Sitting□ Standing□ Laying down□
Lifting□ Bending□ Activities of Daily Living□
Other: _____

7. **Pain is alleviated by**:
Applied Ice □ Applied Heat□ Physical Therapy□
Medications□ Other: _____

8. **Previous Treatment**:
a. ***Injections***: Steroid□ Cortisone□ Viscous□
Other: _____

b. ***Chiropractor Treatment***: Yes □ No□
Name of Chriroprator:_____
Dates Received treatment: _____

c. ***Physical Therapy***: Yes □ No□
Dates Received therapy? _____

HIPAA – PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICIES

*HIPAA – CONSENTIMIENTO DEL PACIENTE PARA USAR Y COMPARTIR INFORMACION PERSONAL DE SALUD Y CONFIRMACION DE RECIBO DE LA NOTA DE PRACTICAS DE PRIVACIDAD

I acknowledge that I have been provided with **JAMES VOGLINO, M.D., P.A.., "**Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

Confirmo que se me ha proveído con la "Nota De Practicas De Privacidad" de* **JAMES VOGLINO, M.D., P.A.., *y doy mi consentimiento para usar y compartir Información Personal De Salud como lo permita y/o requiera la ley.*

Patient Name: *(please print)*

**Nombre Del Paciente: (nombre en letra de molde por favor)*

Patient Signature *(or legal representative; proof may be requested)*

**Firma Del Paciente: (o representante legal; prueba puede ser requerida)*

Date:

**Fecha:*

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM
*CONSENTIMIENTO DE CORREO ELECTRONICO/MENSAJES DE TEXTO A MOVIL

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **JAMES VOGLINO, M.D., P.A.., (JV)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **JV** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **JV** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **JV** and I, and consent to the conditions outlined herein. Any questions I may have had were answered.

***Propósito:** Esta forma es usada como consentimiento de usted para comunicarnos vía correo electrónico/mensaje de texto a móvil en referencia a su Información de Salud Protegida. **JAMES VOGLINO, M.D., P.A.., (JV)** ofrece a sus pacientes la oportunidad de comunicación vía correo electrónico/mensaje de texto a móvil. Trasmitir información vía correo electrónico/mensaje de texto a móvil tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propósitos. **JV** usara formas razonables de proteger confidencial y seguro la información mandada a usted vía correo electrónico/mensaje de texto a móvil. De todas formas, **JV** no podrá garantizarle proteger confidencial y seguro la comunicación vía correo electrónico/mensaje de texto a móvil y no será en ninguna forma responsable si esta información confidencial es usada inadvertidamente por otros.

Yo comprendo haber leído y completamente entendido el consentimiento de esta forma. Yo comprendo los riesgos asociados con la comunicación vía correo electrónico/mensaje de texto a móvil entre **JV** y yo, y consiento a las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido me a sido respondida.

Patient Acknowledgment & Agreement / *Reconocimiento y Acuerdo del Paciente

My Consented Email Address is:

**Mi Correo Electrónico Consentido Es:*

My Consented Mobile Number For Text Messaging is:

**Mi Numero Móvil Para Mensaje De Texto Consentido Es:*

Patient Signature: **Date:**

Firma del Paciente* ****Fecha*

IN CASE OF EMERGENCY: *Please call 911 or proceed to the nearest emergency room.* ***Do not use this way of communication for that purpose.***

****EN CASO DE EMERGENCIA:*** *Por favor llame al 911 or proceda al centro de emergencia mas cercano.* ***No use esta forma de comunicación para este propósito.***

Rev.09/19

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT INFORMATION	
Patient Name:	**Date of Birth:**
Social Security No:	**Telephone No:**
Address:	

RELEASE TO	
I authorize **JAMES VOGLINO, M.D., P.A.**; to release the health information indicated below to: **And** for the purpose of alternative means of confidential communication the use of the following Email Address:	
Person/Organization Name:	
Address:	
Telephone No:	**Email Address:**
Dates of Medical Record Release:	

JAMES VOGLINO, M.D., P.A.., (JV) offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. **JV** will use reasonable means to protect the security and confidentiality of email information sent and received. However, **JV** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication via email and I consent to the conditions outlined herein. Any questions I may have had were answered.

REASON FOR DISCLOSURE		
☐ **Continuing Care**	☐ **Legal**	☐ **Other Purpose** *(please specify)*
☐ **Insurance**	☐ **Personal Use**	

INFORMATION TO BE RELEASED	
☐ **Complete Medical Record**	☐ **Operative Reports**
☐ **Lab Reports**	☐ **Pathology *Reports***
☐ **Radiology Reports**	☐
☐	☐
☐ **Other** *(please specify)*	

SPECIFIC AUTHORIZATIONS	
The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:	
☐ **Drug/Alcohol Abuse or Treatment**	☐ **Genetic Testing Information**
☐ **HIV/AIDS, Sexually Transmitted Disease (STD) Test Results or Diagnoses**	☐ **Mental Health Treatment or Psychotherapy Notes** *(The release of Psychotherapy Notes require a separate authorization)*

This consent is subject to revocation at any time except to the extent the action has been taken thereon. ***This authorization and consent will expire one year from the date of authorization written below.*** Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the recipient may no longer be protected by law.

Patient Signature: *(Guardian/Legal Representative)*	**Date Signed:**
Print Name: *(Please Print)*	**Relationship If Other Than Patient:**

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care).*

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FROM OTHER HEALTHCARE FACILITIES

PATIENT INFORMATION	
Patient Name:	**Date of Birth:**
Social Security No:	**Telephone No:**
Address:	

REQUEST TO	
Name of Healthcare Facility from which Records are Requested:	
Telephone No.:	**Fax No.:**
Address:	
Dates of Treatment Requested:	**Reason For Disclosure:**

I hereby authorize **JAMES VOGLINO, M.D., P.A.; to obtain** the health information indicated below ***AND*** for the purpose of alternative means of confidential communication the use of their email address. **JV** offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. **JV** will use reasonable means to protect the security and confidentiality of email information sent and received. However, **JV** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication via email and consent to the conditions outlined herein. Any questions I may have had were answered.

Mail Information To:	**JAMES VOGLINO, M.D., P.A.**	**Address: 6705 RED RD, #606 CORAL GABLES, FL 33143**
Or Fax To:	**305.665.2724**	**Email: Sportsmedicine@drshoulderhipknee.com**

INFORMATION TO BE RELEASED	
☐ **Complete Medical Record**	☐ **Operative Reports**
☐ **Radiology Reports**	☐ **Pathology Reports**
☐ **Lab Reports**	☐
☐	☐
☐ **Other** *(please specify)*	

SPECIFIC AUTHORIZATIONS	
The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:	
☐ **Drug/Alcohol Abuse or Treatment**	☐ **Genetic Testing Information**
☐ **HIV/AIDS, Sexually Transmitted Disease (STD) Test Results or Diagnoses**	☐ **Mental Health Treatment or Psychotherapy Notes** *(The release of Psychotherapy Notes require a separate authorization)*

This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire one year from the date of authorization written below. Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your healthcare information by the recipient may no longer be protected by law.

Patient Signature: *(Guardian/Legal Representative)*	**Date Signed:**
Print Name: *(Please Print)*	**Relationship If Other Than Patient:**

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18. **For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.*

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Orthopaedic Surgery and Sports Medicine
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Coral Gables, Florida 33143
Phone: 305-596-3707 Fax: 305-665-2724

Financial Policy

This is an agreement between James Voglino, M.D., P.A., as creditor, and the Patient/Debtor named on this form.

By executing this agreement, you are agreeing to pay for all services that are received. Payment is expected at the time services are rendered. We accept cash, personal check, money orders, cashier's check, Visa, Master Card and American Express. We collect copay, coinsurance and any deductible at the time services are rendered.

Insurance:
Insurance is a contract between you and your insurance company. We will file insurance claims only for plans with whom we have a contract with. We participate in some managed care plans. In order to file your claims, we require a legible copy of the front and back of the insurance card, photo ID, social security number and verification of benefits by your insurance company prior to visits. It is the responsibility of the insured/patient to supply current and accurate information for claims submissions. All copay, coinsurance and deductibles are due at the time services are rendered. (practice contracted insurances copays/deductibles are expected to be met promptly and not deferred on LOP-accident cases when such insurance is utilized.)

If you are covered by a plan that we are not participating providers for, payment is expected when services are rendered. We will provide you with an itemized receipt for you to file your insurance. Your insurance company will be responsible for reimbursing you for any coverage you may have.

Collection Fee: A fee totaling 32% (account less than 1 yr old) and 50% (account over one year old) of the balance due will be added to your account if we have to send your account to a collection agency. In addition, an interest at the rate of 1.5% per month (or 18% per year) on any unpaid balance. Plus any and all fees and cost Dr. Voglino incurs to collect any unpaid balance or charges, including his attorney's fees and cost. You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account to any credit reporting agency such as a credit bureau.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Returned checks: There is a fee currently of $25.00 for any checks returned by the bank. Payment made on a returned check must be made in cash or by a money order.

Medical Record requests: You will need to request in writing and pay a reasonable copying fee ($1.00 per page for the first 25 pages and 25 cents for every page thereafter). If you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history. (with our Electronic health record you may request free patient portal access to your records via internet.) Additional charges apply to image (xray) requests, CD's etc.

Ancillary Services: In addition to the visit and procedure fees, the practice routinely provides patients with orthopaedic -related services/goods to optimize convenience, compliance and care - including:
DME (braces)/XRAYS/ Ultrasound/ Medications with additional charges (that may be lower cost elsewhere) but are often but now always covered by insurance.

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Record Review/ No Show visit Charges:
The practice routinely charges for the doctor's reserved time and chart review time for missed or short notice (48 hrs.) cancelled visits (up to $200) as well as for 'extra' outside records that take extra time to review and correlate/store etc. (up to $500/hr.) to optimize evaluation/care.. Current practice policies apply here.

LOP/accident cases: The practice may elect to defer collections on LOP/attorney personal injury cases after insurances pursued for care balances that remain and we will attempt to resolve balances with the attorney.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

My signature below certifies that I have read (or the form has been read to me) and I understand the contents on this form.

Name: _____

Signature: _____ Date: _____

Responsible party (if not the patient): _____Relationship to patient: _____

Updated:3/23/21